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Predictive Value of Self-Reported and Observer-Rated Defense Style in Depression Treatment

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This study explored the predictive value of observer-rated and self-reported defensive functioning on the outcome of psychotherapy for the treatment of depression. Defense styles were measured according to the Developmental Profile (DP) and the Defense Style Questionnaire (DSQ) in 81 moderately severely depressed patients. All patients were treated with Short-term Psychodynamic Supportive Psychotherapy (SPSP).

At baseline, women appeared to have a more mature level of overall defensive functioning. A lower level of defensive function was found in patients with recurrent depressions. We also found a rather modest relationship between self-reported and observer-rated defense.

Remitted patients had a more mature overall defensive functioning on the DP and the DSQ. In particular, patients with a symbiotic defense style (giving up, apathetic withdrawal) were at risk for poor outcome.

This exploratory study provides further evidence of the relevance of defense styles for depression. It suggests a differential predictive value of separate defense levels, which may help to tailor psychotherapeutic strategies.

KEYWORDS: depression, defense style, psychotherapy, therapy, outcome

INTRODUCTION

Even beyond psychoanalytic psychotherapy, defense mechanisms are the most valuable and widely accepted of all psychodynamic concepts (Cramer, 2000). One reason is that their manifestations in behaviors, affects, and feelings can be observed in the daily clinical situation as

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phenomena related to both the etiology of psychopathologic symptoms and the progress of therapy. For instance, throughout therapy, the defense mechanism of anger displacement toward the self may aggravate depressive feelings and hamper the capacity to cope in an adaptive way to depressive symptoms.

Research supports the relevance of defense styles. Vaillant (1993) reported that the maturity of defense is predictive of mental health during life, and in the general population, adaptiveness of a person's defenses appeared to be related better social functioning and lower health care costs (MacGregor 2003). Clinical studies demonstrate that depressed patients use maladaptive defenses and that recovery from depression appears related to concurrent improvement of defense styles (e.g. Akkerman et al., 1999; Kneepkens & Oakly, 1996; Defife et al., 2005; Bloch et al., 1993).

A better understanding of the predictive value of baseline defense scores might be useful because it may help identify patients who could benefit from treatment and patients at risk for poor outcome. Mullen et al. (1999) found image-distorting defenses related to non–adherence to prescribed antidepressant regimens. However, the association with outcome appears to vary across studies (Hoglend & Perry, 1998; Bond & Perry, 2004; Hersoug et al., 2002). In addition, there have been few studies conducted of homogeneous groups of depressed patients treated with psychotherapeutic treatment options.

Self-report questionnaires and observer-rated methods are available to measure defense styles. The most applied instrument is the Defense Style Questionnaire (DSQ), which is an easily administrable and cost-effective self-report questionnaire (Bond et al., 1989; Andrews et al., 1993). Self-report measures of defense mechanisms induce conceptual problems. Defense mechanisms are defined as automatic psychological processes and individuals are often unaware of them. Consequently, a self-report measure only reflects the conscious derivates, but not the defense mechanism itself. Furthermore, the self-report might be sensitive to the influence of current psychopathology, such as a depressed mood or anxiety. This is similar to self-report measure of personality pathology according to the DSM (Bodlund et al., 1998; Zimmerman, 1994). Therefore, interview methods using observer ratings are considered to be the "gold standard" of measuring defense styles. Several procedures have been developed with promising results (Bond 2004). However, the relationship between self-reported and observer-rated methods of diagnosing defenses is unclear. Two studies found only a modest (Perry and Hoglend, 1998) or no association (Hersoug et al., 2002)

In the current exploratory study we investigated defense styles, with both a self-reporting and an observer-based method in a sample of depressed patients allocated to a short-term psychodynamic supportive form of psychotherapy. This allowed us to investigate defense style as a predictor of treatment course and outcome under standardized clinical circumstances. The main research question was: Does maturity of defense style predict a more favorable outcome of psychotherapy for depression? We explored both for the overall rating of defensive functioning and adaptive and maladaptive defense levels. Secondly, we explored differences in defensive functioning among groups of depressed patients. Thirdly, we sought to understand the relationship between the self-reporting and observer-rated methods to determine defense mechanisms and the potential differential influence of severity of the depressive symptoms on these two types of assessments.

METHODS

Patients and Procedure

The patient sample was drawn from a randomized clinical trial (RCT), in which two algorithms of treatment for depression were compared. Patients started either with antidepressants or short-term psychodynamic supportive psychotherapy. We conducted the study at two outpatient facilities of JellinekMentrum Mental Health Care, a large psychiatric teaching hospital in Amsterdam. The general inclusion criteria of the trial were: age 20 to 65 years, a DSM-IV defined major depressive disorder (using Composite International Diagnostic Interview (CIDI) and baseline score of 14 to 25 points on the 17-item Hamilton Depression Rating Scale ([HAM-D] Hamilton, 1967). To obtain the DSM diagnosis, trained residents in psychiatry or psychologists interviewed patients according to the regular intake procedure of the departments. A senior psychiatrist also provided an assessment and consensus on the diagnosis was reached. After the procedures were explained fully, patients gave written informed consent. A separate by preference condition was available in which they could start with either psychotherapy or pharmacotherapy for patients unwilling to be randomized. A detailed description of this study has been published elsewhere (Dekker et al., 2008; Van et al., 2008). All patients who started with psychotherapy, either randomized (n= 40) or by preference (n=41), and for whom a Defense Functioning score was available, were included in this study. Except that more women opted to start with psychotherapy (p=0.49), there were no baseline differences between randomized and by preference patients with respect to sociodemographic

factors, depression characteristics, or in outcome of treatment. The treatment algorithm included a sequential strategy. This means that after 2 months of treatment those patients with less than a 30 % reduction on the HAM-D were offered the venlafaxine, beginning at a dose of 75 mg per day that could be titrated up to a maximum of 225 mg per day. This occurred in 16 patients.

Treatment

The psychotherapy consisted of sixteen sessions of short-term psychodynamic supportive psychotherapy (SPSP). The first eight sessions took place weekly, the last eight fortnightly. The efficacy of this psychotherapy for depression has been demonstrated (e.g., de Jonghe et al., 2004). Short-term psychodynamic supportive psychotherapy is a manual-based approach focusing on the affective, behavioral and cognitive aspects of relationships that can be discussed from both an interpersonal or intrapersonal perspective. Depending on the focus of therapy and the capacities of the patient, the therapists may choose more supportive interventions, for example, encouraging adaptive coping, reducing feelings of guilt, giving praise, or interventions to enhance insight, such as clarification of confrontation. This means that the therapy can be placed on a variable point on the expressive- supportive continuum (Gabbard et al., 2002). At the participating outpatient departments, SPSP is a regular approach for treating depressed patients. The therapists (n=13) were either psychiatrists or psychotherapists. They were trained in the principles of SPSP in a 15–hour course, and needed to finish one or more supervised therapies (depending on previous psychotherapeutic experience) to qualify for treatment in the research setting. Therapist competencies in SPSP were evaluated by one of the supervisors before they were allowed to participate in the current study. The two study supervisors are psychoanalytic psychotherapists, registered with the Dutch Association of Psychoanalytic Psychotherapy. During the research project, the residents and trainees were supervised weekly. The other therapists met biweekly for peer supervision, together with one of the study supervisors. Supervison was based on audiotaped material. The supervisors also controlled for adherence to the psychotherapy manual.

ASSESSMENTS

The Developmental Profile (DP)

The defensive functioning was determined by the developmental profile ([DP] Abraham et al., 2001). In its original form, the DP covers a

Table 1. HIERARCHICALLY CLASSIFIED LEVELS OF DEFENSIVE STYLES IN THE DEVELOPMENTAL PROFILE

		The patient's reactions to internal or external stress are characterized by :	
	Level	Thoughts & feelings	Actions
Adaptive (Mature)	Generativity	Keeping perspective; confronting; humor	Enterprise; anticipation; learning from experience
	Solidarity	Ambivalence: accepting contradictory feelings	Affiliation: sharing problems
	Individuation	Self-control; sublimation	Assertiveness
Maladaptive (Neurotic and immature)	Rivalry	Repression; affect denial; reaction formation	Pretending: feigning or imagining abilities
	Resistance	Rationalization; isolation of affect; displacement	Avoidance; undoing; indecision
	Symbiosis	Apathetic withdrawal	Giving up
	Narcissism	Devaluation	Displaying omnipotence
	Fragmentation	Splitting; projective identification	Acting out
	Lack of Structure	Disavowal; delusional ideas	Autism: displaying strange or bizarre behavior

comprehensive range of psychodynamic personality features, including scales for object relations, defensive functioning and norms. For the purpose of this study, the scores referring to defense functioning were adopted. The semistructured interview, on which the DP is based, consists of anamnestic questions related to important areas of life and relationships of the patients. The interviewer follows the so-called "a-b-c model," which means that for each topic, information is elicited from the patient on (a) affective significance, (b) actual behavior, and (c) cognition. Scoring is based on the verbatim typed up copy of the recorded interview.

The DP defines nine hierarchical levels that range from highly maladaptive to highly adaptive (Table 1). The scoring manual provides definitions and anchor points for each item. The Overall Defensive Functioning (ODF) was computed apart from the separate level scores in a way similar to that proposed by Perry and Hoglend (1998). We obtained this score by the sum of the raw scores of each defense level (Table 1) weighted by its order in the hierarchy and divided by the total number of levels. This yields a score within a theoretical range of 1 to 9. Scores of 1

to 4 reflect immature functioning, scores of 5 to 7 reflect intermediate functioning, and scores of 8 and 9 mature functioning.

Two or three independent raters scored each interview. In total, there were seven raters. Before participating in the study raters were trained in the DP scoring technique and rated at least 10 interviews. Consensus scores were obtained following an established procedure (Van et al., 2000). Specific examples that referred to defensive functioning were recorded by the raters. Only examples on which there was in inmediament agreement between raters, or agreement was reached after a brief verbal clarification, were recorded on the consensus scoring form. If no agreement was reached, the example was not recorded. This procedure ensured that only those manifestations clearly present were included in the consensus scores. The interrater reliability (κ coefficient) was 0.51 for the ODF. For the separate levels the mean κ coefficient was 0.41 (range 0.28-0.64). The mean percentage of concordance judgments was 84% (range 71-93%).

Defense Style Questionnaire (DSQ)

The DSQ is a widely used instrument to measure defense styles. The Dutch translation (Trijsburg et al., 2000) includes 42 items, representing 21 defense mechanisms. Psychometric studies demonstrate various potential options for clustering the individual defense mechanisms in groups (Bond, 2004) all indicating a ranking towards increasing maturity. The original classification as proposed by Andrews et al. (1993) adapted to the 42–item version, was followed: mature defenses (humor, suppression, sublimation, anticipation), neurotic defenses (reaction formation, idealization, undoing), and immature defenses (rationalization, fantasy, displacement, dissociation, isolation, devaluation, splitting, passive aggression, somatization, acting out, projection).

Measurement of outcome variables

Severity of depression was measured at baseline and after 6 months of treatment using the HAM-D-17. Ratings were based on a semistructured interview by independent observers. We established the reliability of the observers' assessments before their participation in the study. Audiotaped assessments were discussed monthly to prevent slippage. Remission (HAM-D $\leq$ 7) was chosen as the primary outcome variable because it does not only provide an optimal result immediately after treatment, but also guarantees the best prognosis and is generally acknowledged as the main goal of depression treatment (Paykel 1998; Trivedi et al., 2006).

Statistical analysis

VA (significance level $p < 0.05$) was used to test differences between baseline characteristics and ODF for DP and DSQ. Pearson correlations were calculated to measure the association between DP and DSQ indices. To obtain a comparable equivalent with the DSQ, the DP levels were combined in adaptive (genearativity, solidarity and individuation), neurotic (rivalry, resistance and symbiosis,) and immature (narcissism, fragmentation and lack of structure).We used ANCOVA to compare all DP and DSQ indices between and remitted or nonremitted patients. Initial severity of depression and addition of medication after two months of treatment (yes or no) were included as covariates.

Subsequently, logistic regression analyses with backward elimination of factors that did not contribute significantly (criterion: $p < 0.10$) were performed with remission (HAM-D-17 $\leq$ 7) as dependent variable in order to identify independent predictors. Analyses concern the variables that appeared to be different in the comparison between remitters and nonremitters. Gender and age were entered as covariables. Finally, the explained variation (Nagelkerke R^2) of the models were computed.

RESULTS

There were three baseline differences between patients groups in overall defensive functioning (table 2). First, on the DP women appeared to have a more mature development of defense styles compared to men. Further exploration of the level scores revealed in particular a difference on the adaptive level of solidarity, i.e. ambivalence and affiliation ($p < .001$). Second, patients with a recurrent depression had less mature defense styles. This was because of differences on all the separate adaptive levels (generativity, solidarity and individuation), however, the maladaptive levels on did not differ. Third, on the DSQ patients who are divorced or widowed had a lower ODF. On the DSQ subscales there appear to be a difference on maturity (Chi square =3.3, p=0.04), not on the maladaptive subscales. Of note, the overall defense scores both on the DP and the DSQ did not differ between patients with lower and higher HAM-D scores. Also, we did not find differences between lower and higher HAM-D scores on any of the DP and DSQ subscales (data not presented).

Table 3, shows the Pearson's correlation between the observer-rated defense of the DP and the self-reported defense according to the DSQ.

Table 2. BASELINE CHARACTERISTICS FOR OVERALL DEFENSE SCORES

Sociodemographics	%	DP-ODF Mean (SD) (n=81)	DSQ-ODF Mean (SD) (n=69)
Gender			
Male	21.0	5.4 (0.8)**,[1]	2.4 (0.2)
Female	79.0	5.8 (0.7)	2.3 (0.2)
Age			
< 40 yr	69.1	5.6 (0.8)	2.3 (0.2)
> 40 yr	30.9	5.8 (0.8)	2.3 (0.2)
Education			
Low	25.7	5.5 (0.8)	2.2 (0.2)
Intermediate	41.9	5.8 (0.6)	2.3 (0.2)
High	32.4	5.7 (0.7)	2.4 (0.2)
Marital status			
Married	22.5	5.7 (0.9)	2.3 (0.1)
Div./widowed	13.8	5.9 (0.9)	2.1 (0.2)*
Never married	63.8	5.6 (0.7)	2.3 (0.2)
Depression:			
Duration (present episode)			
< 1 yr	41.9	5.7 (0.7)	2.3 (0.2)
> 1 yr	58.1	5.5 (0.6)	2.4 (0.2)
Recurrence			
0	48.6	6.0 (0.8)**,[2]	2.3 (0.2)
> 1	51.4	5.4 (0.6)	2.3 (0.1)
Severity			
HAM-D 14-20	54.0	5.6 (0.7)	2.3 (0.2)
HAM-D 20-25	46.0	5.8 (0.8)	2.3 (0.2)

* $P < 0.05$; ** $P < 0.01$

The Pearson's correlation for the ODF was 0.28. No significant correlations were found between the DP adaptive and maladaptive subscales and its DSQ equivalents.

Table 4 presents the difference in defensive functioning between remitted and nonremitted patients after 24 weeks of treatment. In the total sample, 36.5% achieved remission. These patients had a higher overall defensive functioning score according to both the DP and the DSQ. The DP indicated higher scores for remitted patients on the level of rivalry (repression, affect denial) and lower on the symbiotic level (giving up, apathetic withdrawal). The remitted patients scored higher on the maturity

Table 3. PEARSON CORRELATIONS BETWEEN OBSERVER-RATED (DP) AND SELF-REPORTED (DSQ) DEFENSE STYLES

DSQ-DP:	*R*	*P*
ODF	0.28	**0.02**
Adaptive levels	0.07	0.55
Maladaptive, neurotic (rivalry, resistance, symbiosis)	0.14	0.23
Maladaptive, immature (narcissism, fragmentation, lack of structure)	0.04	0.76

subscale of the DSQ, but no differences were found on the maladaptive defense styles.

Additionally, logistic regression analyses were performed to explore further the value of the differences between remitted and nonremitted

Table 4. DEFENSIVE FUNCTIONING AND OUTCOME (HAM-D ≤ 7) FOR SUMSCORES AND LEVEL SCORES OF THE DP (N=81) AND THE DSQ (N=69)

	Remission		*Non-remission*		*Anova*	
	Mean	SD	Mean	SD	F	P
DP						
ODF	6.0	0.7	5.6	0.8	4.0	**0.04**
Adaptive levels:						
Generativity	0.9	0.9	0.7	1.1	0.1	0.73
Solidarity	2.4	1.6	2.2	1.8	0.1	0.75
Individuation	2.6	1.3	2.7	1.2	0.5	0.47
Maladaptive levels:						
Rivalry	2.5	1.7	1.4	1.0	9.2	**0.00**
Resistance	2.6	1.2	2.9	1.4	0.3	0.58
Symbiosis	1.5	1.3	2.5	1.8	6.1	**0.02**
Narcissistic	0.7	1.0	1.0	1.3	2.3	0.13
Fragmention	0.6	1.0	0.8	1.0	0.7	0.41
Lack of structure	0.1	0.2	0.0	0.1	0.8	0.38
DSQ						
ODF	2.4	0.2	2.3	0.2	4.5	**0.04**
Mature	57.0	9.2	47.4	12.2	11.2	**0.00**
Neurotic	71.7	11.9	67.6	12.5	2.1	0.15
Immature	42.7	12.4	47.1	10.7	2.2	0.09

Table 5. LOGISTIC REGRESSION OF FACTORS ASSOCIATED TO OUTCOME (STEPS OF ELIMINATION OF NONSIGNIFICANT FACTORS PRESENTED)

		OR	C.I.	P
DP-ODF				
Step 1	Age	0.99	0.94–1.04	.99
Step 2	Gender	0.26	0.08–0.93	.04
	DP-ODF	2.45	1.15–5.23	**.02**
R^2	15%			
DP: Levels				
Step 1	Age	0.98	0.92–1.04	.67
Step 2	Gender	0.39	0.10–1.53	.18
Step 3	Rivalry	2.12	1.29–3.47	**.00**
	Symbiosis	0.59	0.39–0.91	**.02**
R^2	29%			
DSQ-ODF				
Step 1	Age	0.98	0.93–1.03	.43
Step 2	Gender	0.44	0.14–1.34	.15
Step 3	DSQ-ODF	12.72	1.29–125.18	**.03**
R^2	8%			
DSQ: Factors				
Step 1	Age	0.98	0.93–1.03	.93
Step 2	Immature	0.28	0.96–1.01	.27
Step 3	Gender	0.47	0.15–1.49	.20
Step 4	Mature	1.08	1.03–1.14	**.00**
R^2	19%			

patients. Only the variables that were found to be statistically different according to the ANOVA analyses (See table 4), and age and gender were entered in the analyses. Table 5 shows the results and the steps of the eliminated nonsignificant factors (backwards procedure). With regard to the DP-ODF, both gender and DP-ODF were identified as independent predictor for remission. The explained variation (R^2) was 15%. A main effect was found for both rivalry and symbiosis as predictor for outcome when looking at the separate levels,. The explained variation was 29%.

For the DSQ, the ODF was an independent predictor. With regard to the DSQ factors, the mature defense style predicted outcome. The explained variation was 19%.

DISCUSSION

Our primary finding was that overall defensive functioning, both observer-rated and self-reported, was associated with a better chance on remission of depression after a short-term form of psychodynamic psychotherapy. The study indicates it is worthwhile to determine specific levels of defense, as defense styles classified at the rivalry level were associated with a better outcome, whereas symbiotic defense styles were associated with poor outcome. With regard to the self-reported defense in particular, a mature defense style was predictive for outcome. All associations fell in the expected directions and were consistent with the theory of hierarchical defenses.

At baseline, women were rated higher than men in overall maturity in observer-rated indications of defenses. In contrast, a nonclinical sample found that men and women did not differ in use of defensive strategies (Bullit and Farber, 2002). By combining these data, we can hypothesize that depression may create a differential influence on the stability of defense level in men and women. If confirmed in further studies, for clinical practice it might imply to take into account a less mature developed defense style in male depressed patients. If confirmed by further studies, clinicians may consider more immature defense style in depressed male patients compared to female patients.

Patients with recurrent depression showed less general maturity of defense compared to first-episode depressed patients. We are not aware if this was reported previously, but it is possible that the absence of mature defenses may be a contributing factor for decreased ability to cope with life stressors and resultant increased vulnerability to depressive reactions.

We found a rather modest overall association between DSQ– and DP–measured defensive functioning, and no association at the more specific subscales. A limited concordance of self-report questionnaires and interview–based instruments is not uncommon in diagnosing personality pathology (Perry, 1992; Hersoug et al., 2002). It may be explained by a different method of administration. In contrast to a self-reporting questionnaire, the interview method allows an appraisal by the clinician during the interview and the possibility of continuing questions. This may be even more compelling in cases of defense styles as it concerns largely unconscious phenomena. Nevertheless, the exact relationship between these methods deserves further research. Ideally, this relationship would permit an easily administrable instrument, such as the DSQ, to serve as a general

screener for defense style, while the more costly observer-rated methods could be used as necessary to confirm diagnosis.

Notably, no association with severity of depression was found in either observer-rated and self-reported defense. For the DP, this may be expected because, apart from the fact that in general, observer-rated methods are less sensitive to the influence of concurrent symptoms. The interview protocol provides instructions on how to minimize this. The fact that we did not find these influences for the DSQ, supports the possibility of measuring defense style by a self–reporting method in the presence of moderately severe depressive symptoms.

The psychotherapy delivered was short-term and did not have the aim to achieve structural changes in personality. Theoretically, in such psychotherapies in particular, healthy aspects of personality are considered to be an important precursor to deriving benefit. Therefore, it could be expected that the presence of mature defense styles, independent of the concurrent presence of immature defenses, would be related to outcome. This is concordant with a research finding in which self-observation was identified as a repair mechanism that improves outcome (Hoglend and Perry, 1998). It is in line with the predictive value of a mature defense style, according to the DSQ in our study, although not confirmed with the observer-rated defense.

Our study suggests differential patterns for separate defense levels. This supports the search for a predictive value of specific defense style, even though this appears to be more difficult to assess in a reliable way (Perry & Cooper, 1989; Hummelen, 1997). In addition, from a clinical point of view, a better understanding of specific defense mechanisms of a patient might be more informative compared to general defense scores, as it may better guide the therapist to tailor interventions.

The exploration of the separate levels revealed that a symbiotic defense style, defined as giving up and/or apathetic withdrawal, was related to an untoward outcome. These can be characterized as passive reactions to (life) stressors. All depression treatments, independent of theoretical orientations, require interventions to motivate the patient towards (re)activation, and therefore, these types of reactions usually need to be counterattacked. We can argue that this is a more difficult effort and that it needs more time or perhaps a modification of therapeutic interventions.

On the other hand, patients with higher scores on the level of rivalry were more likely to remit. This means they make more use of defense mechanisms, such as repression, affect denial, or reaction formation. These are all characterized by a process of modifying feelings to prevent (full)

awareness of the emotional significance elicited by a stressor. It may be that in a short-term psychotherapy, these types of defense mechanisms, which refer to neurotic conflicts, can be addressed rather effectively, ultimately resulting in a better outcome.

Limitations

This study focuses on remission, and it did not address long-term effects. In addition, we did not measure whether defense styles actually improved during therapy. This might be important because patients with poor defenses may remain vulnerable to future relapses. As mentioned above, the baseline difference with respect to recurrent depression, also suggests this vulnerability.

The psychometric properties of the DP have been demonstrated for the overall scores (Abraham et al., 2001), but so far not for the defense scores separately. The interrater reliability in this sample expressed as κ coefficients were fair to moderate according to the classification of Landis and Koch (1997). It illustrates that psychodynamic concepts remain complex and difficult to assess. We, therefore, adopted a procedure of simple and transparent decision rules to arrive at clinically sufficiently valid consensus scores.

A final limitation is that SPSP was the only psychotherapy modality we studied. It is not certain to what extent the results are restricted to this form of short-term psychodynamic therapy or if they might be generalized to other psychotherapies for depression. Psychotherapies that specifically aim to improve defensive functioning, such as the affect phobia therapy of McCullough et al. (2003), may be of potential interest for the purpose of comparison.

Strengths

A strength of the present study is that it concerns a group of well–defined patients, all with a major depressive disorder. This is important because in earlier research it was found that associations of defense styles with outcome may be flawed in more heterogeneous populations, due to an unequal influence of defense across disorders (Hoglend & Perry 1998). Furthermore, many of the patients had been treated before, indicating they suffered from refractory depressions. Patients were not specifically selected for psychotherapy. Therefore, they may be representative of the broad group of difficult-to-treat depressed patients commonly referred to outpatient psychiatric services. A final strength is that the defense styles were determined with a self-report and an interviewer–based measure.

This allowed us to address the theoretically important issue of the relationship between these two methods.

CONCLUSION

This exploratory study provides further evidence for the relevance of defense styles for depression by indicating its predictive value for outcome of a short-term psychotherapeutic treatment. It supports the usefulness of measuring defense styles before starting treatment. It also suggests the potentially differential predictive value of separate defense levels. If this holds true in further studies, it may be of help for clinicians in tailoring psychotherapeutic strategies to the individual patient.

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